

MPPA Family Childcare Center Inc. Enrollment Form

Entrance Date: _____ **Withdrawal Date:** _____ **Referred By:** _____

Child's Name: _____ Sex: ___ Age: ___ Date of birth: _____

Home Address (Street): _____ City: _____

State: _____ Zip: _____ Home Phone Number: _____

Father's Name: _____ Cell Phone Number and Carrier: _____

Father's Home Address (if different from child) Street: _____

City: _____ State: _____ Zip: _____

Father's Place of Employment: _____ Work Phone: _____

Father's Email Address: _____

Mother's Name: _____ Cell Phone Number and Carrier: _____

Mother's Home Address (if different from child) Street: _____

City: _____ State: _____ Zip: _____

Mother's Place of Employment: _____ Work Phone: _____

Mother's Email Address: _____

Child's Living Arrangements (check one): () Both Parents; () Mother; () Father; () Other: _____

Child's Legal Guardian(s) (check one): () Both Parents; () Mother; () Father; () Other: _____

The child may be released to the person(s) signing this agreement or to the following:

Name: _____ Cell Phone Number: _____

Relationship to Child: _____ Relationship to Parent(s) or Guardian: _____

Name: _____ Cell Phone Number: _____

Relationship to Child: _____ Relationship to Parent(s) or Guardian: _____

Name: _____ Cell Phone Number: _____

Relationship to Child: _____ Relationship to Parent(s) or Guardian: _____

Name: _____ Cell Phone Number: _____

Relationship to Child: _____ Relationship to Parent(s) or Guardian: _____

Name: _____ Cell Phone Number: _____

Relationship to Child: _____ Relationship to Parent(s) or Guardian: _____

Name: _____ Cell Phone Number: _____

Relationship to Child: _____ Relationship to Parent(s) or Guardian: _____

Emergency Contact

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name: _____ Telephone Number: _____

Name: _____ Telephone Number: _____

Name: _____ Telephone Number: _____

Name of Public or Private School child attends, if any: _____

Child's doctor or clinic name: _____

Doctor/clinic phone #: _____

My child has the following special needs: _____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: _____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: _____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) _____ Date of birth: _____

suffer an injury or illness while in the care of (Facility name) and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian: _____

Signature: _____

Date: _____

Facility Administrator/Person-In-Charge: Pamela Lewis

Signature: Pamela Lewis

Date: _____

Parental Agreements with Child Care Facility

MPPA Family Childcare Center Inc. agrees to provide child care for

_____ on _____ (am/pm) to _____ (am/pm)

(Name of Child) (# of Days of Week)

from _____ to _____.

(Month/Year) (Month/Year)

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast / Morning Snack / Lunch

Afternoon Snack / Dinner / Evening Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date, name of child, name of medication, prescription number (if any), dosages, and the date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The facility agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for

MPPA Family Childcare Center Inc.

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____ Date: _____

(Parent/Guardian)

Signed: Pamela Lewis Date: _____

(Facility Administrator/Person-In-Charge)

MPPA Family Childcare Center Inc.

Parents or Guardian's

Notice of No Liability Insurance and Acknowledgement

I understand that I am being informed in writing by signing this acknowledgement that this facility, MPPA Family Childcare Center Inc., does not carry liability insurance sufficient to protect my child/children in the event of an injury, etc. MPPA Family Childcare Center Inc. shall not be responsible for providing or paying for the child's health care. I agree that neither I, nor my child will bring any claims of any kind against MPPA Family Childcare Center Inc. and it's employees, as a result of injuries, expenses or damages that I or my child may suffer in any way related to the use of the facilities, toys, other children and/or teachers, whether such claims are known or unknown or arise in the future.

Parents/guardian's Signatures

Date

Parent/guardian (Print Names)

Date

Pamela Lewis

Center Director Signature

Date

MPPA Family Childcare Center

Parent Contract with MPPA

- Before any medication is dispensed to my child, I will provide a written authorization, which includes: date, name of the child, name of medication, prescription number, if any, dosages, date and time of day of any medications is to be given. Medicine must be in the original container with my child's name marked on it.
- My child will not be allowed to leave the facility without being escorted by an authorized parent, guardian or facility personnel.
- The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc. which include my child.
- I authorize the facility to obtain emergency medical care for my child when I am not available
- I have received a copy and agree to abide by the policies and procedures for MPPA Family Childcare Center Inc.
- I acknowledge that it is my responsibility to keep my child's records current to reflect any significant changes as they may occur, e.g, telephone numbers, work location emergency contacts, child's physician, child's health status, immunization and feeding plans.
- Parents must give written notice 2 weeks prior to leaving of their intent to withdraw their child from the facility
- Prayer and Christian religious instruction is incorporated at this facility
- I understand that the center will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____

Date: _____

Parent/ Guardian

Signed: *Pamela Lewis*

Facility Administrator

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses: **Rockdale Medical Center**

Address: **1412 Milstead Ave Conyers, GA 30012.**

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if MPPA cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Director: *Pamela Lewis*

Date _____

MPPA

Standard Photo and Video Release Form for Minor Children

I hereby authorize **MPPA Family Childcare Center Inc. (MPPA)** to publish the photographs and videos taken of me and/or the undersigned minor children, and their names for use in **MPPA** printed publications, websites, and for training purposes.

I release **MPPA** From Any Expectation of confidentiality for the undersigned minor children and myself and attest that I am the parent or legal guardian of the children listed below and that I have the authority to authorize **MPPA** to use their photographs, videos, and names.

I acknowledge that participation in publications and websites produced by **MPPA** is voluntary, neither the minor children nor I will receive any financial compensation.

I further agree that participation in any publication and websites produced by **MPPA** confers no rights of ownership whatsoever. I release **MPPA**, its employees and its contractors from liability for any claims by me or any third party in connection with my participation or the participation of the undersigned minor children.

I do not authorize **MPPA Family Childcare Center Inc. (MPPA)** to publish the photographs and videos taken of me and/or the undersigned minor children, and their names for use in **MPPA** printed publications, websites, and for training purposes.

Signature: _____ Date: _____

Printed Name: _____

Street Address: _____

City/State/Zip: _____

Names and Ages of Minor Children:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____

Safe Sleep Practices Policy

Child's name: _____ Date of birth: _____

Parent/Guardian name: _____

Safe Sleep Practices/Policies:

- 1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.
- 2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.
- 3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.
- 4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.
- 5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.
- 6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the above practices throughout the center.
- 7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.
- 8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.
- 9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature: _____ **Date:** _____

**MPPA Family Childcare Center Inc.
Rules and Regulations Handbook
2125 Old Salem Rd.
Conyers, Ga. 30260
(Revised Handbook 1/3/2018)
(Effective date 1/3/2018)**

I, _____, by my signature below, attest that I have received a copy of these rules and regulations. I further attest that I have read and understand these policies and rules and I agree to abide by them. Failure to abide to the policies and procedures of MPPA Family Childcare Center Inc. will result in child dismissal from the center. A copy of the handbook and billing notice will be sent to the email address that was provided.

Signature (Parent/Guardian)

Date

Printed Name (Parent/Guardian)